



General Assembly

January Session, 2011

Committee Bill No. 17

LCO No. 767

00767SB00017INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

**AN ACT CONCERNING WELLNESS PROGRAMS AND EXPANSION
OF HEALTH INSURANCE COVERAGE.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-492j of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2012*):

3 Each individual health insurance policy providing coverage of the
4 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
5 469 delivered, issued for delivery, renewed, amended or continued in
6 this state that provides coverage for ostomy surgery shall include
7 coverage, up to [one] five thousand dollars annually, for medically
8 necessary appliances and supplies relating to an ostomy including, but
9 not limited to, collection devices, irrigation equipment and supplies,
10 skin barriers and skin protectors. As used in this section, "ostomy"
11 includes colostomy, ileostomy and urostomy. Payments under this
12 section shall not be applied to any policy maximums for durable
13 medical equipment. Nothing in this section shall be deemed to
14 decrease policy benefits in excess of the limits in this section.

15 Sec. 2. Section 38a-518j of the general statutes is repealed and the

16 following is substituted in lieu thereof (*Effective January 1, 2012*):

17 Each group health insurance policy providing coverage of the type
18 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
19 delivered, issued for delivery, renewed, amended or continued in this
20 state that provides coverage for ostomy surgery shall include coverage,
21 up to [one] five thousand dollars annually, for medically necessary
22 appliances and supplies relating to an ostomy including, but not
23 limited to, collection devices, irrigation equipment and supplies, skin
24 barriers and skin protectors. As used in this section, "ostomy" includes
25 colostomy, ileostomy and urostomy. Payments under this section shall
26 not be applied to any policy maximums for durable medical
27 equipment. Nothing in this section shall be deemed to decrease policy
28 benefits in excess of the limits in this section.

29 Sec. 3. (NEW) (*Effective January 1, 2012*) (a) As used in this section,
30 "prosthetic device" means an artificial limb device to replace, in whole
31 or in part, an arm or a leg, including a device that contains a
32 microprocessor if such microprocessor-equipped device is determined
33 by the insured's or enrollee's health care provider to be medically
34 necessary. "Prosthetic device" does not include a device that is
35 designed exclusively for athletic purposes.

36 (b) (1) Each individual health insurance policy providing coverage
37 of the types specified in subdivisions (1), (2), (4), (11) and (12) of
38 section 38a-469 of the general statutes delivered, issued for delivery,
39 renewed, amended or continued in this state shall provide coverage
40 for prosthetic devices that is at least equivalent to that provided under
41 Medicare. Such coverage may be limited to a prosthetic device that is
42 determined by the insured's or enrollee's health care provider to be the
43 most appropriate to meet the medical needs of the insured or enrollee.
44 Such prosthetic device shall not be considered durable medical
45 equipment under such policy.

46 (2) Such policy shall provide coverage for the medically necessary
47 repair or replacement of a prosthetic device, as determined by the

48 insured's or enrollee's health care provider, unless such repair or
49 replacement is necessitated by misuse or loss.

50 (3) No such policy shall impose a coinsurance, copayment,
51 deductible or other out-of-pocket expense for a prosthetic device that is
52 more restrictive than that imposed on substantially all other benefits
53 provided under such policy, except that a high deductible health plan,
54 as that term is used in subsection (f) of section 38a-493 of the general
55 statutes, shall not be subject to the deductible limits set forth in this
56 subdivision or under Medicare pursuant to subdivision (1) of this
57 subsection.

58 (c) An individual health insurance policy may require prior
59 authorization for prosthetic devices, provided it is required in the
60 same manner and to the same extent as is required for other covered
61 benefits under such policy.

62 (d) An insured or enrollee may appeal a denial of coverage for or
63 repair or replacement of a prosthetic device to the Insurance
64 Commissioner for an external, independent review pursuant to section
65 38a-478n of the general statutes.

66 Sec. 4. (NEW) (*Effective January 1, 2012*) (a) As used in this section,
67 "prosthetic device" means an artificial limb device to replace, in whole
68 or in part, an arm or a leg, including a device that contains a
69 microprocessor if such microprocessor-equipped device is determined
70 by the insured's or enrollee's health care provider to be medically
71 necessary. "Prosthetic device" does not include a device that is
72 designed exclusively for athletic purposes.

73 (b) (1) Each group health insurance policy providing coverage of the
74 types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
75 469 of the general statutes delivered, issued for delivery, renewed,
76 amended or continued in this state shall provide coverage for
77 prosthetic devices that is at least equivalent to that provided under
78 Medicare. Such coverage may be limited to a prosthetic device that is

79 determined by the insured's or enrollee's health care provider to be the
80 most appropriate to meet the medical needs of the insured or enrollee.
81 Such prosthetic device shall not be considered durable medical
82 equipment under such policy.

83 (2) Such policy shall provide coverage for the medically necessary
84 repair or replacement of a prosthetic device, as determined by the
85 insured's or enrollee's health care provider, unless such repair or
86 replacement is necessitated by misuse or loss.

87 (3) No such policy shall impose a coinsurance, copayment,
88 deductible or other out-of-pocket expense for a prosthetic device that is
89 more restrictive than that imposed on substantially all other benefits
90 provided under such policy, except that a high deductible health plan,
91 as that term is used in subsection (f) of section 38a-520 of the general
92 statutes, shall not be subject to the deductible limits set forth in this
93 subdivision or under Medicare pursuant to subdivision (1) of this
94 subsection.

95 (c) A group health insurance policy may require prior authorization
96 for prosthetic devices, provided it is required in the same manner and
97 to the same extent as is required for other covered benefits under such
98 policy.

99 (d) An insured or enrollee may appeal a denial of coverage for or
100 repair or replacement of a prosthetic device to the Insurance
101 Commissioner for an external, independent review pursuant to section
102 38a-478n of the general statutes.

103 Sec. 5. Section 38a-490b of the general statutes is repealed and the
104 following is substituted in lieu thereof (*Effective January 1, 2012*):

105 Each individual health insurance policy providing coverage of the
106 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
107 469 delivered, issued for delivery, renewed, amended or continued in
108 this state [on or after October 1, 2001,] shall provide coverage for

109 hearing aids for children [twelve] eighteen years of age or younger.
110 Such hearing aids shall be considered durable medical equipment
111 under the policy and the policy may limit the hearing aid benefit to
112 one thousand dollars within a twenty-four-month period.

113 Sec. 6. Section 38a-516b of the general statutes is repealed and the
114 following is substituted in lieu thereof (*Effective January 1, 2012*):

115 Each group health insurance policy providing coverage of the type
116 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
117 delivered, issued for delivery, renewed, amended or continued in this
118 state [on or after October 1, 2001,] shall provide coverage for hearing
119 aids for children [twelve] eighteen years of age or younger. Such
120 hearing aids shall be considered durable medical equipment under the
121 policy and the policy may limit the hearing aid benefit to one thousand
122 dollars within a twenty-four-month period.

123 Sec. 7. Subsection (a) of section 38a-504 of the general statutes is
124 repealed and the following is substituted in lieu thereof (*Effective*
125 *January 1, 2012*):

126 (a) Each insurance company, hospital service corporation, medical
127 service corporation, health care center or fraternal benefit society that
128 delivers, issues for delivery, renews, amends or continues in this state
129 individual health insurance policies providing coverage of the type
130 specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-
131 469 [.] shall provide coverage under such policies for the surgical
132 removal of tumors and treatment of leukemia, including outpatient
133 chemotherapy, reconstructive surgery, cost of any nondental
134 prosthesis including any maxillo-facial prosthesis used to replace
135 anatomic structures lost during treatment for head and neck tumors or
136 additional appliances essential for the support of such prosthesis,
137 outpatient chemotherapy following surgical procedure in connection
138 with the treatment of tumors, and a wig if prescribed by (1) a licensed
139 oncologist for a patient who suffers hair loss as a result of
140 chemotherapy, or (2) a licensed physician or a licensed advance

141 practice registered nurse for a patient who suffers hair loss due to a
142 diagnosed medical condition of alopecia areata other than as a result of
143 androgenetic alopecia. Such benefits shall be subject to the same terms
144 and conditions applicable to all other benefits under such policies.

145 Sec. 8. Subsection (a) of section 38a-542 of the general statutes is
146 repealed and the following is substituted in lieu thereof (*Effective*
147 *January 1, 2012*):

148 (a) Each insurance company, hospital service corporation, medical
149 service corporation, health care center or fraternal benefit society that
150 delivers, issues for delivery, renews, amends or continues in this state
151 group health insurance policies providing coverage of the type
152 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
153 shall provide coverage under such policies for treatment of leukemia,
154 including outpatient chemotherapy, reconstructive surgery, cost of any
155 nondental prosthesis, including any maxillo-facial prosthesis used to
156 replace anatomic structures lost during treatment for head and neck
157 tumors or additional appliances essential for the support of such
158 prosthesis, outpatient chemotherapy following surgical procedures in
159 connection with the treatment of tumors, a wig if prescribed by (1) a
160 licensed oncologist for a patient who suffers hair loss as a result of
161 chemotherapy, or (2) a licensed physician or a licensed advance
162 practice registered nurse for a patient who suffers hair loss due to a
163 diagnosed medical condition of alopecia areata other than as a result of
164 androgenetic alopecia, and costs of removal of any breast implant
165 which was implanted on or before July 1, 1994, without regard to the
166 purpose of such implantation, which removal is determined to be
167 medically necessary. Such benefits shall be subject to the same terms
168 and conditions applicable to all other benefits under such policies.

169 Sec. 9. (NEW) (*Effective January 1, 2012*) (a) Subject to the provisions
170 of subsection (b) of this section, each individual health insurance
171 policy providing coverage of the type specified in subdivisions (1), (2),
172 (4), (11) and (12) of section 38a-469 of the general statutes delivered,

173 issued for delivery, amended, renewed or continued in this state shall
174 provide coverage for expenses arising from human leukocyte antigen
175 testing, also referred to as histocompatibility locus antigen testing, for
176 A, B and DR antigens for utilization in bone marrow transplantation.

177 (b) No such policy shall impose a coinsurance, copayment,
178 deductible or other out-of-pocket expense for such testing in excess of
179 twenty per cent of the cost for such testing per year. The provisions of
180 this subsection shall not apply to a high deductible health plan as that
181 term is used in subsection (f) of section 38a-493 of the general statutes.

182 (c) Such policy shall:

183 (1) Require that such testing be performed in a facility (A)
184 accredited by the American Society for Histocompatibility and
185 Immunogenetics, or its successor, and (B) certified under the Clinical
186 Laboratory Improvement Act of 1967, 42 USC Section 263a, as
187 amended from time to time; and

188 (2) Limit coverage to individuals who, at the time of such testing,
189 complete and sign an informed consent form that also authorizes the
190 results of the test to be used for participation in the National Marrow
191 Donor Program.

192 (d) Such policy may limit such coverage to a lifetime maximum
193 benefit of one testing.

194 Sec. 10. (NEW) (*Effective January 1, 2012*) (a) Subject to the provisions
195 of subsection (b) of this section, each group health insurance policy
196 providing coverage of the type specified in subdivisions (1), (2), (4),
197 (11) and (12) of section 38a-469 of the general statutes delivered, issued
198 for delivery, amended, renewed or continued in this state shall provide
199 coverage for expenses arising from human leukocyte antigen testing,
200 also referred to as histocompatibility locus antigen testing, for A, B and
201 DR antigens for utilization in bone marrow transplantation.

202 (b) No such policy shall impose a coinsurance, copayment,

deductible or other out-of-pocket expense for such testing in excess of twenty per cent of the cost for such testing per year. The provisions of this subsection shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520 of the general statutes.

(c) Such policy shall:

(1) Require that such testing be performed in a facility (A) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and (B) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time; and

(2) Limit coverage to individuals who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

(d) Such policy may limit such coverage to a lifetime maximum benefit of one testing.

Sec. 11. Section 38a-492k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state [on or after October 1, 2001,] shall provide coverage for colorectal cancer screening, including, but not limited to, (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. [Benefits] Except as specified in subsection (b) of this section, benefits under this section shall be subject to the same terms and conditions

233 applicable to all other benefits under such policies.

234 (b) No such policy shall impose a coinsurance, copayment,
235 deductible or other out-of-pocket expense for any additional
236 colonoscopy ordered in a policy year by a physician for an insured.
237 The provisions of this subsection shall not apply to a high deductible
238 health plan as that term is used in subsection (f) of section 38a-493.

239 Sec. 12. Section 38a-518k of the general statutes is repealed and the
240 following is substituted in lieu thereof (*Effective January 1, 2012*):

241 (a) Each group health insurance policy providing coverage of the
242 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
243 469 delivered, issued for delivery, amended, renewed or continued in
244 this state [on or after October 1, 2001,] shall provide coverage for
245 colorectal cancer screening, including, but not limited to, (1) an annual
246 fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or
247 radiologic imaging, in accordance with the recommendations
248 established by the American College of Gastroenterology, after
249 consultation with the American Cancer Society, based on the ages,
250 family histories and frequencies provided in the recommendations.
251 [Benefits] Except as specified in subsection (b) of this section, benefits
252 under this section shall be subject to the same terms and conditions
253 applicable to all other benefits under such policies.

254 (b) No such policy shall impose a coinsurance, copayment,
255 deductible or other out-of-pocket expense for any additional
256 colonoscopy ordered in a policy year by a physician for an insured.
257 The provisions of this subsection shall not apply to a high deductible
258 health plan as that term is used in subsection (f) of section 38a-520.

259 Sec. 13. (NEW) (*Effective January 1, 2012*) (a) Any insurer, health care
260 center, hospital service corporation, medical service corporation,
261 fraternal benefit society or other entity that delivers, issues for
262 delivery, renews, amends or continues in this state a group health
263 insurance policy providing coverage of the type specified in

subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall offer a reasonably designed health behavior wellness, maintenance or improvement program that allows for a reward, a health spending account contribution, a reduction in premiums or reduced medical, prescription drug or equipment copayment, coinsurance or deductible, or a combination of these incentives, for participation in such program.

(b) Any such incentive or reward shall not exceed twenty per cent of the paid premiums and shall comply with all nondiscrimination requirements under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder.

(c) The insured or enrollee shall provide evidence of participation in such program to the insurer, health care center or other entity set forth in subsection (a) of this section in a manner approved by the Insurance Commissioner.

(d) The Insurance Commissioner, in consultation with the Commissioner of Public Health, may adopt regulations, in accordance with chapter 54 of the general statutes, to establish the criteria and procedures for the approval of such health behavior wellness, maintenance or improvement programs.

Sec. 14. Section 38a-825 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

[No] Except as provided in section 13 of this act, no insurance company doing business in this state, or attorney, producer or any other person shall pay or allow, or offer to pay or allow, as inducement to insurance, any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement not specified in the policy of insurance. [No] Except as provided in section 13 of this act, no person shall receive or accept from any company, or attorney,

295 producer or any other person, as inducement to insurance, any such
296 rebate of premium payable on the policy, or any special favor or
297 advantage in the dividends or other benefit to accrue thereon, or any
298 valuable consideration or inducement not specified in the policy of
299 insurance. No person shall be excused from testifying or from
300 producing any books, papers, contracts, agreements or documents, at
301 the trial of any other person charged with the violation of any
302 provision of this section or of section 38a-446, on the ground that such
303 testimony or evidence may tend to incriminate him, but no person
304 shall be prosecuted for any act concerning which he is compelled to so
305 testify or produce documentary or other evidence, except for perjury
306 committed in so testifying.

307 Sec. 15. Subdivision (9) of section 38a-816 of the general statutes is
308 repealed and the following is substituted in lieu thereof (*Effective*
309 *January 1, 2012*):

310 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,
311 38a-488, 38a-825, as amended by this act, 38a-826, 38a-828 and 38a-829.
312 None of the following practices shall be considered discrimination
313 within the meaning of section 38a-446 or 38a-488 or a rebate within the
314 meaning of section 38a-825, as amended by this act: (a) Paying bonuses
315 to policyholders or otherwise abating their premiums in whole or in
316 part out of surplus accumulated from nonparticipating insurance,
317 provided any such bonuses or abatement of premiums shall be fair and
318 equitable to policyholders and for the best interests of the company
319 and its policyholders; (b) in the case of policies issued on the industrial
320 debit plan, making allowance to policyholders who have continuously
321 for a specified period made premium payments directly to an office of
322 the insurer in an amount which fairly represents the saving in
323 collection expense; (c) readjustment of the rate of premium for a group
324 insurance policy based on loss or expense experience, or both, at the
325 end of the first or any subsequent policy year, which may be made
326 retroactive for such policy year; (d) paying a reward, making a health
327 spending account contribution, or allowing a reduction in premiums

328 or reduced medical, prescription drug or equipment copayment,
 329 coinsurance or deductible, or a combination of these incentives to an
 330 insured or enrollee in accordance with section 13 of this act.

331 Sec. 16. Section 38a-623 of the general statutes is repealed and the
 332 following is substituted in lieu thereof (*Effective January 1, 2012*):

333 No society doing business in this state shall make or permit any
 334 unfair discrimination between insured members of the same class and
 335 equal expectation of life in the premiums charged for certificates of
 336 insurance, in the dividends or other benefits payable thereon or in any
 337 other of the terms and conditions of the contracts it makes. [No] Except
 338 as provided in section 13 of this act, no society, by itself, or any other
 339 party, and no agent or solicitor, personally, or by any other party, shall
 340 offer, promise, allow, give, set off or pay, directly or indirectly, any
 341 valuable consideration or inducement to or for insurance, on any risk
 342 authorized to be taken by such society [, which] that is not specified in
 343 the certificate. [No] Except as provided in section 13 of this act, no
 344 member shall receive or accept, directly or indirectly, any rebate of
 345 premium, or part thereof, or agent's or solicitor's commission thereon,
 346 payable on any certificate or receive or accept any favor or advantage
 347 or share in the dividends or other benefits to accrue on, or any
 348 valuable consideration or inducement not specified in, the contract of
 349 insurance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2012</i>	38a-492j
Sec. 2	<i>January 1, 2012</i>	38a-518j
Sec. 3	<i>January 1, 2012</i>	New section
Sec. 4	<i>January 1, 2012</i>	New section
Sec. 5	<i>January 1, 2012</i>	38a-490b
Sec. 6	<i>January 1, 2012</i>	38a-516b
Sec. 7	<i>January 1, 2012</i>	38a-504(a)
Sec. 8	<i>January 1, 2012</i>	38a-542(a)
Sec. 9	<i>January 1, 2012</i>	New section

Sec. 10	<i>January 1, 2012</i>	New section
Sec. 11	<i>January 1, 2012</i>	38a-492k
Sec. 12	<i>January 1, 2012</i>	38a-518k
Sec. 13	<i>January 1, 2012</i>	New section
Sec. 14	<i>January 1, 2012</i>	38a-825
Sec. 15	<i>January 1, 2012</i>	38a-816(9)
Sec. 16	<i>January 1, 2012</i>	38a-623

Statement of Purpose:

To expand or require health insurance coverage for ostomy-related supplies, prosthetic devices, hearing aids for children, wigs for patients who suffer hair loss due to certain medical conditions, and bone marrow testing; to prohibit the imposition of a coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured; to promote health behavior wellness, maintenance or improvement program participation by requiring insurers to offer such programs, and to require an incentive or reward for such participation.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. CRISCO, 17th Dist.

S.B. 17